MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-62-012531

STATE FILE NUMBER

FILED APR 6 1962 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3126

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS:

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED | BY AFFIDAVIT OF | DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips
Inside Limits: Yes X No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes X No ☐
d. STREET ADDRESS (If outside, give location): 1254 N. Euclid
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Jenolia Middle Last Carter
4. DATE OF DEATH: Month 3 Day 19 Year 62
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☐ Widowed X Divorced ☐
8. DATE OF BIRTH: 9-28-1918
9. AGE (last birthday): 43
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed
10b. KIND OF BUSINESS OR INDUSTRY: Unemployed
11. BIRTHPLACE (City and state or country): Miss
12. CITIZEN OF WHAT COUNTRY: U.S.A
13a. FATHER'S NAME: Jones Carter
13b. MOTHER'S MAIDEN NAME: Sharlett Brown
14. NAME OF HUSBAND OR WIFE: None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Marie Miller 785 N. Euclid Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for PART I.)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Apoplexy;
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Hemorrhage of the Choroid plexus;
DUE TO (c): Pneumonia (secondary)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 331 X

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES X NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from to and last saw her/him alive on
Death occurred at 7:05 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Paul Hamon Deputy Coroner
22b. ADDRESS: 300 Clark
22c. DATE SIGNED: 3/23/62

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 3/24/62
23c. NAME OF CEMETERY OR CREMATORY: Father Dickson
23d. LOCATION (City, town, or county) (State): Kirkwood Mo

24. FUNERAL DIRECTOR: ADDRESS: A. H. Burks 3901 Ashland
25. DATE RECD. BY LOCAL REG.: MAR 23 1962
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed_____

Licensed Embalmer No. 4441

P. O. Address 3901 Ashland

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.